Proposition 63 Begins

The Mental Health Services Act

Implementation Toolbox by Mark Ragins, M.D.

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Introduction

The year 2004 may be remembered as the year Christmas came early to California's mental health supporters. The voters approved hundreds of millions of dollars annually to build the community mental health system promised almost 40 years ago when the state hospitals were closed.

Some saw the successful initiative as a last inning home run by Assembly Member Darrell Steinberg. Others were impressed by the ability of the nonprofit mental health agencies to organize under Rusty Selix and work to write and pass Proposition 63. From my seat, I've seen a lot of effort and money over the last 15 years come from the National Mental Health Association of Greater Los Angeles under Richard Van Horn's leadership. These three were joined by hundreds of tireless workers on the campaign.

The day after Election Day, I gave a presentation on "Strategies to Reach the Promised Land" at a CASRA (California Association of Social Rehabilitation Agencies) conference. Not knowing until the last minute whether I'd be talking about implementing Proposition 63 or dealing with disappointment, I brought along a set of rough papers as handouts. My presentation was well received. My favorite comment on the evaluation sheets was, "Subject matter sounds unrealistic, but the closer you look at it, the more feasible it sounds." Thanks to Julia Scalise and Sara Ford, those papers were polished up a bit, and I've added several others to form this packet. Some of these papers are value statements or strategy guides. Others are "to do check lists" or evaluation guidelines.

That day I felt happy, but burdened. We've been given a great gift here. With that gift comes a burden. Now we have a serious obligation to build a truly transformed, effective mental health system. Here's what I've collected in my toolbox so far.

Recovery-Based System Transformation Strategies:
What Should We Do?

We have come to the point where it is realistic to think about how we could promote a transformation of the mental health system into a recovery-based system. We are clearer about what a recovery system would include than about how we are going to get there. Given the likelihood that many people will be resisting this transformation, it behooves us to be clear about our strategies.

This paper is a list of proposed strategic goals. The pursuit of these goals will need to be highly individualized for each program, organization and county. In other words, this is a list of ideas of where we should be going, not how we're going to get there. Nonetheless, I think it's worth breaking down our lofty recovery vision into more manageable goals.

1) Spread understanding of, and belief in, recovery and inspire people to want recovery-based programs.
2) Incorporate quality of life outcome data and cost data into program monitoring and accountability.
3) Incorporate quality of life program elements (money management, employment, supportive housing, community integration, substance abuse treatment, supportive education, etc.) into mental health programs, which will lead to the creation of integrated services.
4) Hire consumers widely within mental health programs in a variety of roles as part of increased consumer involvement overall.
5) Create recovery-oriented infrastructures (charting, goal setting, funding, etc.).
6) Create recovery-oriented leadership and cultures.
7) Change practice expectations to value recovery practices (collaboration, empowerment, self-help training, lowering boundaries, multiple roles, self-disclosure, increased *real* emotional interactions, long-term relationships, etc.). Train and retrain staff in these changed practices, especially professionals.
8) Build community coalitions (law enforcement, housing, education, employment, etc.) to advocate for changes in mental health services that benefit society widely and to document outside cost savings of our practices.
9) Incorporate engagement strategies for people we struggle to serve who are of important social interest (homeless, jail diversion, institutionalized, transitional youth, etc.).

There are substantial ongoing efforts in all of these goal areas and even some experience in the options of how to pursue them effectively in different situations. Transformations of social systems are notoriously hard to achieve. We'll have to work hard.

Socially-Responsible Mental Health Services

A short time ago, a confused 50-year-old woman was picked up at the Los Angeles Airport. She had no belongings or identification and said she was trying to get to Los Angeles. The police took her to the county psychiatric hospital. She told the hospital her name was Julia Smith, she was homeless and had a mental illness.

Computer records showed that she'd been seen by a jail mental health unit four times and was hospitalized five times in the last couple years, but had not received any outpatient treatment. The hospital called us at the MHA Village to see if we would help her. We sent a staff to the hospital the next day to meet Julia and offered to help her after she left the hospital. A few days later, the hospital discharged her and had an ambulance drop her at our door. It was a Friday afternoon, and Julia was penniless and without a plan.

We didn't panic. We arranged to pay for a hotel for the weekend and gave her $40 for food and cigarettes. I'm the psychiatrist and I talked with her that afternoon. She didn't make much sense, was distant emotionally and couldn't focus. I guessed Julia had schizophrenia, but there were no records. I checked that she had a two-week supply of pills and knew how to take them. At her request, I looked through the phone book for a nearby Baptist church, but that was too confusing for her. We'd arrange for someone to go with her to church later on if she still wanted to go. We offered her a toiletry kit and a brush, but she wanted a comb instead. We didn't have one. Out of our five engagement strategies—charity, medications, emotional connection, substance abuse empathy, and spiritual connection—only charity seemed to be working.

On Monday another one of our staff picked Julia up at the hotel. The manager reassured us that there had been no problems. Our staff took Julia to the Social Security office and waited with her for three hours only to be told that Julia had been cut off two years ago. Apparently Julia's mother, who was her payee, died and then they made Julia her own payee. When she didn't respond to requests for medical re-evaluation, Social Security determined she was no longer ill. She'd been homeless ever since. They told us they couldn't restart her benefits. They gave her an appointment in two weeks to begin the reapplication process, and told her to bring a birth certificate. She didn't have one. She would have no money for the several months it takes to approve SSI benefits.

We didn't panic. We made up a budget and prepared to spend a few thousand dollars of our own to keep her housed and fed. Hopefully, we'll get most of it back from Social Security, but the two week delay in filing cost us about $500 off the top. We sent the form and payment for a birth certificate to Pittsburgh, where Julia was born. I checked in with Julia again. We still didn't have a comb. Later that afternoon another staff saw her panhandling at the grocery store across the street from the Village. She told Julia very sternly that she shouldn't beg there. If she wanted to live in Long Beach she had to be a good neighbor. The store customers don't like begging and the police would be called on her again. We invited her back to the Village for lunch.

None of this is very dramatic. I didn't do any complicated diagnostic assessments, medication management, or insightful therapy. We did a lot of practical grunt work and spent some money. Socially responsible mental health services often look more like refugee services than treatment. Services often include welcoming, giving charity, redocumenting, assisting with benefits, training in how to be a good neighbor/citizen, helping to find a niche, and advocating. Sometimes it seems like we're a lost and found for people … except that no one ever comes to reclaim most of them.

Years ago, if people with mental illnesses couldn't function in society or behaved badly, they weren't held responsible. They were given asylum in institutions away from society's demands. There are no more asylums. Now they are held responsible and often evicted, jailed, or just plain rejected because of the things they do. Similarly, mental health workers were sheltered away in the institutions. So long as there were no severe scandals, we could do as we pleased. Mental health workers continue to hide behind a wall of confidentiality and a maze of psychiatric jargon. We want to be paid and left alone. We know what's best. We're the experts. It's time for us to be held responsible by society, too.

No more saying we'll only treat certain types of Axis 1 diagnoses, when it's obvious we're turning away people that are disabled. No more saying, "I'm sorry you're homeless, but our next appointment is in six weeks. How would January 8 at 1:30 be?". No more telling distraught families, "We can't do anything if your brother won't come in to see us unless he's dangerous." There is no law against outreach. Instead of coming with an ambulance and restraints, we can come with a lot of listening, some resources, and a willingness to meet people where they're at.

At the MHA Village, we can, and do, show up at the library when the librarian calls concerned about a homeless man pacing around talking to himself and upsetting everyone. We can, and do, show up at jail to meet people before they're released, to pick them up and pay for a room. Similarly, when the police get a call at night about a young woman wandering around confused they can take her to a hotel for the night at our expense and leave us a message so we'll pick her up the next morning and work out a plan. If we expect our communities to fight NIMBY and accept us, we have to be part of the solution, not part of the problem.

When I drive to work, I often pass the crossing guard with her yellow vest and hand-held stop sign who helps the kids get safely to school to learn and grow. Often I smile and wave at her. Sometimes I think our job is to be crossing guards for people with mental illnesses. We help them get around safely so they can learn and grow, too. Often we go with them to Social Security, the welfare office, court, medical doctors' offices and hospitals, the housing office, vocational rehabilitation, college disabled students' office, and church. None of these places are easy for people with mental illnesses – or even "normal" people – to navigate. They often need someone to help them get what they need safely. We don't wear yellow vests, but it would be nice if you'd smile and wave at us instead of telling us to get out of here with "those people."

Socially responsible mental health services can go even further. We can be the Social Security payee for people. We can do employment training and job development, apartment finding and support, substance abuse treatment, and even parenting support. In each of these cases we need to be careful we're creating support for people with mental illnesses to be part of

the community, not a protected alternative to the community. In each of these cases we're helping people recover their place in the world and we should be held accountable for achieving that goal. We can, and should, report how many people we helped get off the street, out of jail, in safe housing, in jobs, and caring for their children. These are the core of socially responsible outcome measures.

There are many obstacles to creating socially responsible mental health services. Many staff don't want to do this kind of work. We haven't been trained to do it and it's not what we expected our jobs to be. Our program designs support our refusal; "that's not our job." The other systems and the community at large don't want us there. They want us to protect and remove people with mental illnesses. Stay in your clinics and hospitals far from sight. Our major funding source, MediCal, is a "medically necessary" system and simply won't pay for socially responsible services if they're not medically based. San Francisco seems to have a new mantra, "We don't do social admissions to psychiatric hospitals."

By now, it's clear to everyone that this just isn't working. We need to integrate medically responsible and socially responsible services to have an effective mental health system. The recovery model has given us a vision of how to do this. Proposition 63 has given us the opportunity to build it. We now have the chance to hire and train new staff and retrain old staff. We can redesign our programs. We have funding available that can be separated from medical necessity. We have new resources in a time when other systems do not. We can help them save a lot of money, so we should be a more desirable partner now. We can create a record of effectiveness and showcase it to fight stigma and build inclusiveness. We can build a socially responsible mental health system, helpful to those that need it and accountable to those who are paying for it.

Implementing Proposition 63, the Mental Health Services Act, With Vision and Purpose

Proposition 63, the Mental Health Services Act, has been hailed as the most important mental health act in California since deinstitutionalization. It provides a breathtakingly large expansion of mental health service funding. Its promoters intend to "fulfill the promise of care" for the thousands of people released from state hospitals and "complete our mental health system." Excitement and hope abound.

Funding for Innovation:

Since our mental health system has long suffered from severe under-funding, hands will be extended everywhere begging for needed funds. There are many people who support our current system. They believe that we don't need to change the system; we need to fund it adequately. They will point to months-long waiting lists at clinics; staff with caseloads in the hundreds; extremely short hospital stays and no bed availability; lack of long-term care beds; closure of state hospitals, day treatment and residential care facilities; and over crowded emergency rooms. They will urge that the new money be spent there.

Unfortunately for them, that is not what this act mandates. This act states that "the funding shall only cover portions of the costs of services that cannot be paid for with other funds" and describes its "purpose and intent…(is) to expand the kind of successful, innovative service programs for children, adults and seniors begun in California," specifically citing the AB 2034 programs. Nonetheless, it will be difficult to push aside hands from so many truly needy existing programs.

Administration for Innovation:

It is clear that this act is not designed to create more "business as usual." It establishes an intertwined system of administrative oversight, training, adult and children systems of care, prevention, and inventive programs clearly designed to promote ongoing innovation and improvement of services. The description of the Prevention and Early Intervention Programs specifically includes that "the department shall revise the program…in future years to reflect what is learned." The Education and Training Program includes "curriculum to train and retrain staff."

Overall there is a planfullness to Proposition 63, with ongoing cycles of reevaluating, learning, applying new learning, and improving programs. If successful, an administrative structure will be created that promotes ongoing program evolution and improvement. That would be a very different administrative structure than we have today. Administrative change will be deceptively difficult, because existing mental health administrations have so many other pressing goals (risk management, budgeting predictability, ease of auditability for outside funders, ease of administration, etc.) that will continue to work against program innovation and evolution.

Social and Political Responsibility:

This act promotes a sense of social responsibility for mental health programs. Just as people with mental illnesses are no longer hidden away and shielded from their social responsibilities, neither is the mental health system. The act mandates us to reduce consumers' "incarcerations," "school failures," "unemployment," and "homelessness." It expects us to potentially save "hundreds of millions of dollars annually on a statewide basis from reduced costs of state prison and county jail operations, medical care, homeless shelters, and social services programs."

The Oversight and Accountability Commission includes only one mental health professional and no mental health administrators. It is to be filled with "outsiders" representing various social and political interests. If programs expect to gain funding from this Commission, they will need to embrace social responsibility. It would behoove us to create local coalitions, planning committees, and advisory boards that similarly reflect social and political interests.

This act also promotes an increased responsibility to the individuals we serve and their families. Not content with the traditional medical model, doctor-patient responsibility, it mandates we go further. It goes beyond the illness-reduction responsibilities to reduce "suicide" and "prolonged suffering" to the more global responsibility to "reduce the long-term adverse impacts on individuals, families." It also mandates "cultural competency."

Quality of Life Focused Services:

Our goal needs to be not just treating the symptoms of mental illness, but improving the lives of people living with mental illnesses. Proposition 63 repeatedly emphasizes the inclusion of both medical services and support services. It allocates funds "to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."

In general, the "uncovered services" are the support services. These services often consist of the individual attention people with severe mental illnesses need to access other programs that are too hard for them to use without help. A few examples: Many people need a payee to use their SSI checks to get food, clothing, and shelter. Social Security doesn't provide payees and mental health treatment funds don't cover money management services. Similarly, most people with severe mental illnesses lose their Section 8 certificates and therefore their housing without extra support. Proposition 63 funds would pay for these essential support services. A lofty goal like "assisting people in quickly regaining productive lives" requires both treatment services and supportive services.

This requires a power shift from the present system where treatment services are "medically necessary" and funded, and the support services are nice, elective add-ons if all the medical needs are met and extra, unrestricted funds exist. This is not to say that treatment services will diminish. In fact, enrolling people in AB 2034 programs routinely increases their treatment services substantially.

Proposition 63 anticipates this increase and funds education and training programs "in order to increase the supply of professional staff and the other staff." But the act says that it's just as legitimate to hire a restaurant manager to do employment training as a psychiatrist to prescribe medications, or a money manager to teach budgeting as a psychologist to do group therapy. All of these roles will be needed to "save lives."

Quality of Life Outcome Measurement:

The AB 2034 programs have collected quality of life outcomes since their inception. Their ability to document powerful effectiveness, especially in decreased homelessness, incarceration and hospitalization and increased employment, has been instrumental to their ongoing funding and the political support for these programs. Measurement breeds accountability. The AB 2034 outcome measurement tools are a tested, feasible starting point for including individualized outcome measurements in all programs funded by Proposition 63. Funding contracts should include quality of life outcome data collection costs.

Integrated Services:

In order for people with severe mental illnesses to use a variety of treatment and support services effectively, they need to be offered within a single program. Past efforts to create a "system of care" that consisted of a range of specialized service agencies collaborating to various degrees has meant that "for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery."

This act promotes the "innovative approach" of AB 2034 to create an "integrated services" system with "a full range of integrated services to treat the whole person." While it may be effective for programs to specialize in working with people with special, underserved needs, it is rarely effective to force people to go to multiple agencies to get all the services they need.

Increased Consumer and Family Roles:

This act frees consumers and their families from the highly restricted roles of "patients" and "collaterals" they have in traditional services. They are included in the local planning processes. They are included in the Oversight and Accountability Commission. They are included in the Education and Training program. This act actively and concretely promotes the "nothing about us without us" viewpoint. Being this inclusive is a true challenge and learning experience.

Probably most powerful in this regard is this act's mandate to include "promotion of the employment of mental health consumers and family members in the mental health system." No single experience is a stronger stigma reducer, "us versus them" barrier breaker, or humanizer than working alongside consumers and family members. No single experience is more likely to change the entire mental health culture. To achieve this outcome they need to be hired not in separate consumer-run programs, and not as separate consumer or family member staff, but as our peers and teammates.

Recovery Vision and Culture:

One of the most potentially controversial mandates of this act is that "planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers." Services must "promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination." Many people will mistakenly interpret this section as a political statement included to gain support of the consumer movement, without practical programmatic implications; words to be sprinkled on government documents without meaning.

Unless we truly incorporate the Recovery Vision in our programs we will not succeed. The most successful innovative programs have created a new culture: a recovery culture. The traditional treatment culture may have been successful in the asylums and university hospitals where it was developed, but it is ill suited to our present needs. The major goals of this act – reaching out to underserved populations, employment, inclusion of consumers and their families, social responsibility and outcomes, integration of treatment and support services, reduction in stigma – cannot be addressed effectively within the traditional treatment culture, but they can be achieved within a recovery culture. In other words, the Recovery Vision is the tool that can finally make the dream of deinstitutionalization a proud reality.

Cultural change is difficult. Almost by definition, culture is the things we take for granted, things we assume have to be the way they've always been, that we pass on from generation to generation in so many ways. It's unrealistic to expect programs to change their cultures just because it would be more effective. There's too much inertia and too much vested interest in the existing culture. In addition, the present infrastructure of our mental health system supports the traditional treatment culture, not the recovery culture. In numerous ways, from funding mechanisms to administrative priorities, from service fragmentation to staff hiring patterns, from training programs to paperwork requirements, recovery is systematically undermined. It will require intensive, intentional efforts to build recovery cultures. It will require many inspiring voices.

The true opportunity that the Mental Health Services Act gives us is the combination of new funds to establish new programs along with a new infrastructure designed to promote recovery. We might not have such a golden opportunity again. We must implement this act with vision and purpose.

The Mental Health Services Planning Process

The largest mental health planning process ever is now underway in counties throughout California. At stake is hundreds of millions of dollars, the transformation of an entire system, and the lives of tens of thousands of people with mental illnesses.

You've always imagined what it would be like to build a dream house, if you ever had the money, and now you do. It's time to move from dreaming to planning.

The first step in the process is to submit a statement on how you will plan your system in order to get your share of the $12.5 million planning money by April.

It's time to bring the family (of stakeholders) together to talk about your shared goals and visions. What do you already have? What do you need? What are your priorities? Remodel the kitchen or build a new driveway? Should a swimming pool be in the plan at all? What have you built in the past? How did it go? Will your plans meet government requirements? How much do you want to coordinate or build yourself? Do you want a contractor or just some builders? Maybe you should talk to a few contractors, get some ideas, hear their sales pitch, and perhaps even hire one.

You need to organize your stakeholder process, decide who your planners are and if you're going to use consultants, set up a planning process, and create a budget.

The second step in the process is to create a countywide three-year plan to submit to the state in July to get adult system of care money. This money will be distributed according to demonstrated need. Your funds won't flow until your plan succeeds in getting state approval.

There are so many decisions to make. You need blueprints, work plans, timetables, and budgets. Everything has to fit together – the electricity, plumbing, building, painting – and you need to live in your house while you're building. What do you enlarge, remodel, add-on, destroy and rebuild? If everybody is so busy fighting over what their new room will look like, it will be hard to focus on how the whole house will fit together.

There are several important things that a successful plan must include. You can create a focused planning process by addressing each of them.

A successful plan should embody a recovery vision and an AB 2034-style integrated services approach.
- Is everyone involved – your stakeholders, planners, programs – well enough versed in these approaches to create a plan that will truly embody them, or will it be vulnerable to criticism for using them just as "window dressing"?
- Do all the stakeholders see how they'll fit into a recovery system or are they scared of being left out?

You need to get everyone on the same page, talking the same language, understanding how recovery works at all levels, and even becoming enthusiastic about it. You need to begin to develop and support a group of your own "recovery champions" to provide ongoing leadership and direction. It's better to "train the leaders" instead of "train the trainers."

A successful plan should base services on consumer needs.
- Service needs must be based on consumers' stages of recovery. Do they need engagement? Empowerment? Self-help? Community integration? Do you have tools for assessing recovery stages and needs?
- How are you going to connect meeting these needs with creating the outcomes for which we're going to be responsible?

This step focuses on the consumers, family members, and community stakeholders. You need to facilitate these discussions so the product is based on recovery stages, quality of life outcomes, and social responsibility, instead of just clinical needs. This will be a new way of creating a needs assessment. Part of your job will be to help people make the mind shifts that are required.

A successful plan should focus beyond just treating illnesses to actively helping to improve the lives of people who have mental illnesses.
- You will be held responsible for quality of life outcomes. Can you measure them?
- Can you add the support services – employment, housing, financial, educational, health, substance abuse, and community integration – to your clinical services to create integrated services?
- Can you blend funding sources, staff, and treatment cultures into a recovery culture?

This step focuses on building the program elements and accountability infrastructure to meet people's needs. The AB 2034 programs have developed an outcome data collection system statewide. You need to build similar outcome measures and accountability into your plan. Your program leaders need to learn how to build support systems and, more importantly, how to merge them into a seamless integrated services program.

A successful plan should describe how your existing capacity is going to be increased.
- Existing services will need to be re-evaluated to assess not just their capacity to take care of people but to promote recovery. Can you track people's recoveries?
- Increasing capacity by doing more of the same is not going to be funded, so forget it. Increasing capacity will have to be achieved by transforming services. How will you approach it? By improving engagement and thoughtful triage? Integrating services? Promoting growth and recovery?

This step focuses on the providers and administrators. This is where decision making will begin to flow upward from consumer, family, and community needs rather than the usual downward from funders and administrators. You need to facilitate discussions so your plan includes not just how individual programs will meet people's needs, but also how they fit together into a coherent system, and hopefully beyond that to how the mental health system will collaborate with other systems involved in people's lives.

What if you build a huge new house and nobody changes their lifestyle? You might end up staying in the old living room watching TV while the new rooms are just for show. Wasn't the point of a dream house to create a dream life?

A successful plan should describe how transformation is going to be created at all levels.
- How will consumers and their families move from adversarial advocacy to collaboration, become more responsible for their own recoveries and less expectant of caretaking and protection, and participate actively in the system at all levels, including employment?
- How will staff make major changes to roles, boundaries, risk taking, empowerment, collaboration, coaching, teamwork, community integration, hopefulness, growth promotion, and working alongside people with mental illnesses?
- How will programs and their leaders create recovery cultures that emphasize hope, healthy uses of authority, healing and community integration?
- How will systems, their administrators and their auditors build recovery values into the infrastructures and accountability measures that are used and make sure power is flowing up from consumers' needs rather than down from funders' requirements?
- How will communities create new coalitions and help people with mental illnesses be integrated into the community?

If you've done a good job of facilitating to this point, the seeds of transformation will already have been laid. However, most of this transformation will not occur until after the planning is done and work really begins. What you need at this point of the process are coherent training and consultation plans, built into your start-up costs, that will promote transformation as the system is being created. The effectiveness of your transformation supports will be crucial to your overall success.

The third step, building your transformed system, will begin after October when your plan is approved and funded by the state.

The building has begun. Your dreams and plans are taking form. There are problems of course, lots of new decisions to make, alterations in the plans. There are even opportunities you didn't see until you were actually in the new rooms. How about a skylight in the bathroom? A bird feeder outside the kitchen window? You also begin to realize that the new house is changing you. You're already dreaming new dreams and planning new plans. A dream house isn't an end at all. It's an ongoing improvement.

Recovery-Based System Planning

Each implementation step of Proposition 63 is an opportunity to develop recovery principles and practices for that step. If we take advantage of all the opportunities, in a few years we will transform our system in California, and we will create blueprints and models for recovery-based transformation elsewhere, too. We should begin by using recovery-based principles throughout our planning.

The California Department of Mental Health wants Proposition 63 plans to be based on needs (both met and unmet) and capacity to meet those needs. Traditionally, we determine needs by calculating how many people have certain illnesses, at certain severities. From that we calculate the need for treatment services like clinic visits, crisis services, and hospital beds. That's not a recovery-based approach.

From a recovery point a view, people can be divided into three groups, irrespective of their diagnosis: 1) "unengaged," 2) "engaged, but poorly self-directed," and 3) "self-responsible."

People who are "unengaged" generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are "engaged, but poorly self-directed" might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are "self-responsible" not only collaborate in their recovery, they can coordinate it.

The three groups are not dependent entirely on consumer traits. System traits, primarily "engageability" and "directability," also affect who is in which group. For example, there were many people who went to the Mental Health Association's Homeless Assistance Program who wouldn't go to a local mental health clinic to make appointments and get medications. However, when I started handing out pills at HAP's drop-in center, most of them wanted to take pills. They weren't really "medication resistant." They were "clinic resistant." When I changed the "engageability" of psychiatric services, many of them changed from "unengaged" to "engaged, but poorly self-directed." Similarly, it is far easier for consumers to coordinate their own services if they are available at one site in an integrated services program, instead of scattered in several separate systems.

Here is an example of how these stages could be used to assess my community's needs and present capacities, and to make highly focused transformation recommendations based on our present problems. Your community will probably have some differences. I also offer services that the Mental Health Association has developed, either at our MHA Village integrated services program or at the Project Return: The Next Step consumer-run program, as possible models.

Stage 1: Unengaged

Entrance to stage:
- Identification of need for mental health services

Recovery goal:
- Trust, hope, goal setting, and planning

Common needs:
- Crisis management
- Charity/"entitlements"/quality of life support services and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening
- Engagement into treatment and thoughtful triage
- Recovery support – acceptance, sanctuary

Present capacity:
- Hospitals, emergency services, long-term locked treatment
- Police, jail
- Co-located mental health workers in social service settings – welfare office, housing, Social Security, education, homeless assistance, vocational rehabilitation, courts, police teams
- Primary health care settings

Present problems:
- These programs often provide crisis management without engagement or charity without engagement. It is rare to see even two of these functions integrated, although the vast majority of people need all three together.
- Virtually all present capacity is short term, episodic settings.
- Some people appear to be "persistently unengageable." They might be appropriate for involuntary outpatient treatment. Opponents of this coercive approach claim, rather persuasively, that if there was better engagement there might not be "persistently unengageable" people left to coerce.

Transformation recommendations:
- Integrate the three service needs into long-term community-based settings.
- Create a close link between settings where people are currently seen briefly to integrated settings where they can get longer, proactive services.

MHA Village Models:
- Outreach and Engagement and Fast Track programs

Stage 2: Engaged, but poorly self-directed

Entrance to stage:
- Engagement with mental health services
- Collaboration in own recovery

Recovery goal:
- Empowerment, self-responsibility

Common needs:
- Mental health treatment, often including crisis management
- Quality of life support services and advocacy – housing, financial, employment, education, substance abuse treatment, physical health,

community integration, family strengthening
- Recovery support – acceptance, sanctuary, healing, self-responsibility, attaining meaningful roles in the community

Present capacity:	• "Structured" programs and environments – IMDs, board and care facilities, day treatment • ACT teams • Integrated Service programs – ISAs, AB 2034 programs
Present problems:	• Most of these people are being treated in outpatient clinics that lack the capability to intensively coordinate care, resulting in too many dropouts, erratic service utilization, frequent crisis, and poor outcomes. • Programs that rely on structure and limit choices to make it easier to coordinate services are generally ill-suited to promoting empowerment and self-responsibility. • Only the ACT teams and Integrated Service programs have substantial capability to do assertive outreach to re-engage people when they disengage.
Transformation recommendations:	• Transform structure-based cultures to recovery-based cultures. • Add ACT and integrated services capabilities to clinics so people can be triaged to the level of service they need.
MHA Village Models:	• Neighborhoods, Transition Age Youth Team

Stage 3: Self-responsibility

Entrance to stage:	• Has ability to coordinate services • Sets and pursues quality of life goals with minimal assistance • Self-directs crisis management
Recovery goal:	• Community integration, attaining meaningful roles, graduation from system
Common needs:	• Mental health treatment, often including self-directed crisis management • Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening • Recovery support – acceptance, sanctuary, healing, self-responsibility, attaining meaningful roles in the community, self-help, giving back, graduation
Present capacity:	• Outpatient clinics • Private psychiatrists, HMOs • Self-help programs • Wellness Centers

Present problems:	• Although these people are "high functioning," they often have needs beyond maintenance mental health treatment, but the system often doesn't have additional services for them. It is rare to have good accessibility to quality of life resources.
	• We don't provide them the services they need in an integrated way, so it is difficult for them to be self-directed. It is rare for one program to integrate mental health services, recovery support, and quality of life resources.
	• Programs have difficulty responding to crisis in empowering, responsive ways. They usually send people in crisis back to the same crisis services "unengaged" people go to where they are treated inappropriately.
	• Graduation from the system is a rare outcome and generally not promoted.
Transformation recommendations:	• Integrate needed services into one program, including self-directed crisis management.
	• Create effective linkages into these programs and out of them.
MHA Model:	• Wellness Center

Many programs care for people, but do not help them progress through these stages. If we expect people to progress through the stages, we need to be especially attentive to the transition points: identification, engagement, empowerment, and graduation.

There is an enormous number of people outside this schema, before identification and after discharge. We assume they don't need mental health treatment on the one hand or no longer need treatment on the other, but both groups are more complicated than that.

The "before identification" group includes numerous "normal" people. However, it also includes people who have serious mental illnesses, but for a variety of reasons have never been identified. These people should be a target for the Prevention and Early Detection programs.

In addition, there are many people who have requested mental health services, but are turned away because they aren't in the "target population" of people with serious mental illnesses. This screening process was created more than a decade ago to focus services on the most needy by removing the "worried well" from caseloads. My remembrance is that Los Angeles County's system removed about half of the people it served at the time, but we were never able to increase the number of people with serious mental illnesses served because of ongoing budget cuts. There is an ongoing, serious, realistic concern that if this screening is reduced, the underfunded system would be overwhelmed by too many people in need. It is hard to be welcoming when the main job is to turn away as many people as possible.

The screening tool is diagnostically based, "Major Mental Illness on Axis I," rather than disability based, so people with primary post-traumatic stress, anxiety, eating, personality, and substance abuse disorders are to be screened out regardless of level of impairment. Many times this screening is done cursorily, even over the phone, without regard to what services might, or might not, be available for them outside the mental health system. Very rarely is a true diagnostic assessment, needs assessment, and community based service plan done. The net

effect is that the "before identification" group includes a substantial number of needy people with mental illnesses who are "rejected" and end up unserved anywhere. We generally don't keep track of who we reject.

The "after discharge" group has six sets of people: 1) people who move away, 2) people who move outside the public sector for their mental health care, 3) people who become disengaged and are lost to follow-up, 4) people whose problems improve and no longer feel in need of services, although they didn't recover, 5) people who recover and graduate, and 6) people who we discharge because of unacceptable behavior (usually violence, substance abuse, non-compliance, or stealing).

If we consider each of these sets individually, quite a number of needs emerge – transfer coordination, assertive re-engagement, relapse prevention education, graduation services, specialized programs for unsafe people – along with possible system transformations. It is likely that if we followed our discharges, few of them would be "no longer in need."

The system belief underlying many of these groups' problems is that the system only survives because of an ability to turn away and discharge people in need. With very limited "positive flow" in our system – people moving to lower levels of service and even graduating – and with new people coming to our doors every day in need, programs are nearly always "full."

Very little attention and resources are spent on these groups because of our guilt feelings over our role in creating them, and because we believe that attending to their needs would create more work rather than less. There is no belief that either better assessments or community service planning on the one hand, or better transfer coordination, assertive re-engagement, or graduations on the other hand would payoff. Changing this belief is an important, often unrecognized, piece of overall system transformation.

Therefore, a complete planning process requires two more stages:

Stage 0: Unidentified

Entrance to stage:
- Experiencing distress, disruption, or wanting help with life
- Being in a high risk group
- Experiencing early warning signs

Recovery goal:
- Prevention, increased self-awareness, and decreased stigma and avoidance of help

Common needs:
- Welcoming and acceptance in destigmatized, initial mental health contacts
- Screening for mental illnesses, risk factors and warning signs
- Collaborative diagnostic assessment, needs assessment, and community-based service planning, whether eligible for mental health services or not
- Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening

Present capacity:	• Mental health public awareness, education, and screening campaigns • Mental health help lines – referrals, suicide prevention, NAMI, MHA, etc. • Telephone and walk-in screening at many mental health programs • Outreach programs – homeless, police, jail, etc. • Co-located mental health workers in social service settings – welfare office, housing, Social Security, education, homeless assistance, vocational rehabilitation, courts
Present problems:	• There is extremely limited funding to spend time with people who are not already identified clients of the mental health system. As a result, almost all programs have essentially eliminated these services. Services tend to be provided by charitable agencies often detached from the overall system. • There is insufficient awareness of and collaboration with other community mental health and social service agencies to make realistic plans and referrals. • The present diagnostically-based screening tool excludes many people who are the neediest; is not responsive to the community's social needs; and is easily distorted, often for humane reasons, but may lead to incorrect diagnoses and treatments as a result. • Cultural factors have a profound impact on help-seeking behavior and stigma generally and require high levels of specialization to be successful.
Transformation recommendations:	• Create funding streams for these services to be integrated into present programs, probably from a combination of Prevention and Early Detection and Adult System of Care funds. • Increase collaboration with other community-based agencies. • Change the screening criteria for eligibility for public funded mental health services from a diagnostically based tool to an impairment and social disruption based tool. • Increase culturally specialized programs.
MHA Village Models:	• "No wrong door;" outreach and engagement; phone screening/triage, which provides a quick response as well as active referrals for individuals who do not have serious mental illnesses

Stage D: Discharged

Entrance to stage:	• Discharge from services – people who: 1) move away, 2) move outside the public sector for mental health care, 3) become disengaged and are lost to follow-up, 4) improve and no longer feel in need of services, although they didn't recover, 5) recover and graduate, and 6) are discharged because of unacceptable behavior (violence, substance abuse, non-compliance, stealing)
Recovery goal:	• Depending on situation, transfer between providers, re-engagement, or graduation and relapse prevention

Common needs:	• Facilitation of service transfers, which includes planning, supported contact, transfer of records, and management of relationship changes • Assertive re-engagement services • Re-entry services • Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening • Specialized services for people who cannot be treated safely in other programs and are discharged or refused services as a result
Present capacity:	• Modest discharge planning services in many programs • Assertive re-engagement in ACT and integrated services programs • Jail and prison services, forensic state hospitals beds, Conditional Release Program, Parole Outpatient Clinic, long term locked treatment
Present problems:	• Most programs do not have a vested interest in improving their discharge programs or re-engaging drop-outs, because they are not usually responsible for assisting people later on if there are problems. Their responsibility to serve people is episode-based, not lifetime-based. • There is a pervasive lack of belief in true recovery, graduation, or the ability for people to become independent of the mental health system. Also, unfortunately, many of our other values and practices, like acceptance, re-engagement, and lifetime-based responsibility, can conflict with promoting graduation. As a result, many programs and practices tend to hinder these achievements rather than promote them. • The specialized programs available are either accessed through the criminal justice system or acute hospitals, both generally unreliable partners because of their own overriding concerns. This is another, though very different, possible niche for involuntary civil commitments, but considerable police support will be needed to make it safe and effective.
Transformation recommendations:	• More programs, especially in Stage 1 and 2, should have "no fail," lifetime based responsibility enrollments. These programs would have to incorporate facilitated transfers, assertive re-engagement, and monitored discharges in their practices. • Create an inspirational cohort of successfully recovered graduates. • Track unsafe people, so they aren't repeatedly discharged only to be readmitted by other unaware programs and so specialized plans and programs can be specifically developed for them.
MHA Village Models:	• "No fail," lifetime-based responsibility enrollments, facilitated transfers, assertive re-engagement, monitored discharges • "Main Street" program to facilitate flow, successful discharges, and graduation

As we progress in our planning and implementation, there will be a tendency to want to rely on doing things in familiar ways. We want to respect the expertise we've accumulated over the years. We don't want to "reinvent the wheel." But if we only do things in familiar ways, we will only generate familiar plans and programs. We will invent only wheels, and we want more than that. Hopefully, this paper has demonstrated a format for a recovery-based planning process that you can use in your community.

12 Aspects of Staff Transformation

There is a lot of talk about transforming our mental health system into a consumer-driven, recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff requires a proactively guided process of staff transformation to succeed. This paper describes 12 aspects of transformation.

1. <u>Looking Inward and Rebuilding the Passion</u>: Recovery work requires staff to use all of themselves in passionate ways to help people. It can't be done effectively in a detached, routine way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, as staff, we need to remember why our hearts brought us to this field in the first place. For many, our hearts have been buried under bureaucracy, paperwork, funding shortages, frustrations, and burn out. We must be nurtured, encouraged to play and explore, bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must treat its staff well before further transformation can occur.

2. <u>Building Inspiration and Belief in Recovery</u>: Staff spend the vast majority of our time and emotions on people who are doing poorly or are in crisis. We neglect success stories of those we help and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and known in darker times. We need to be familiar with the extensive research that documents recovery and the concept of the "clinicians' illusion" that gets in the way of us believing in this research. It is crucial to keep hearing about and believing in people who achieve things we "know are impossible."

3. <u>Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives</u>: Recovery staff treat "people like people," not like cases of different illnesses. To achieve this, we need to fight the numerous ways in which the pervasive culture of medicalization is reflected in the infrastructure. Goal setting needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.

4. <u>Moving from Caretaking to Empowering and Sharing Power and Control</u>: Staff have generally adopted a caretaking role toward people with a mental illnesses. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and consumers are comfortable with them. Analogous to how parents must stop being caretakers for our children to become successful adults, staff

must stop being caretakers for the people we work with to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns as staff try to become more empowering. There may also be personal issues around power and control. Most of us feel most efficient and effective when we are in control and people are doing what we want them to. Frustration is likely to grow when we face repeated failures or crises. We are likely to reject collaboration and want to take more power and control.

5. <u>Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles</u>: Recovery requires breaking down the "us vs. them" walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. To work alongside them as peers (not as segregated, second-rate staff) is probably the single most powerful stigma reducing and transforming experience for staff. For people with mental illnesses to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups and art shows where staff and people with mental illnesses interact in different roles.

6. <u>Valuing the Subjective Experience</u>: Staff have been taught to observe, collect, and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve a partnership, staff must appreciate not just what's wrong with a person, but how that person understands and experiences what's happening. Knowing what it would be like to be that person, what they're frightened of, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, "case conferences" (shouldn't these be "people conferences"?), team meetings, and supervision should value subjective understandings.

7. <u>Creating Therapeutic Relationships</u>: Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, prescription, and compliance. Staff can be interchangeable, professionally distant, even strangers, as long as the diagnosis, plan and compliance are preserved. Recovery work relies on the same foundations as psychotherapy: (1) an ongoing, trusting, collaborative, working relationship, (2) a shared, explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals together. Staff need to gain – or regain – these skills. Program designs must put a priority on relationships so staff can create relationships.

8. <u>Lowering Emotional Walls and Becoming a Guiding Partner</u>: People repeatedly tell us that we are the most helpful when we are personally involved, genuinely caring, and "real." Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance are barriers to lowering emotional walls. Staff needs lots of discussion and administrative support to change because of these strong contrary forces. To best support people on their path of recovery, staff need to act not as detached experts giving them maps and directions, but as guides, becoming

involved and walking alongside them, sharing the trip. Staff's emotional and physical fears of the people we work with need to be dealt with in order to lower the walls.

9. <u>Understanding the Process of Recovery</u>: Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed and treated, symptoms are relieved, and function is regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a different process – the process of recovery. Analogous to the grief process found in hospices, this process can be described by four stages: (1) hope – believing something better is possible, (2) empowerment – believing in ourselves, (3) self-responsibility – taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity. Staff grow in their understanding of the recovery process and their skills in promoting recovery.

10. <u>Becoming Involved in the Community</u>: Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, and to find their niches. Recovery cannot be achieved while people are segregated from their communities. To support this, staff must work in the community. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.

11. <u>Reaching Out to the Rejected</u>: Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well in the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight." All of these people have different serious obstacles to engagement and treatment. Because staff may bring our own prejudices against them, a "counter-culture of acceptance" needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. System transformation will not be considered a success if we continue to reject these people in need.

12. <u>Living Recovery Values</u>: "Do as I say, not as I do" is never a good practice. When the walls and barriers are reduced and emotional relationships are enhanced in a good recovery program, it's even harder for staff to hide. We must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.

By describing these 12 aspects of staff transformation, I have tried to create both a proactive curriculum for staff transformation and a guide for recovery-oriented leaders to use in program design, supervision, and staff support.

A Guide for Recovery-Oriented Leaders

As we attempt to transform our mental health system to a recovery-based system, it is important that we actually transform our culture. We can't just change the sign on the door and do the same old things inside. To be able to tell the difference, we must be able to identify the core elements of a recovery culture when we see them. The MHA Village has made several efforts in this regard. This paper attempts to define the four broad elements of recovery culture we have identified for recovery-oriented leaders: hope, authority, healing, and community integration.

1) **Hope**: Hope is clearly the first step in anyone's recovery and our culture must actively promote it.
    1) Stories and celebrations of hope should be spread by both staff and consumers.
    2) The program should be filled with living examples of hope by hiring people who are open about their mental illnesses.
    3) Goal setting for both consumers and staff should focus on growth rather than stability or risk avoidance, building on strengths as well as overcoming obstacles.

2) **Authority:** The distribution of authority has widespread implications for promoting empowerment, self-responsibility, risk-taking, and growth from mistakes for both staff and consumers.
    1) Decentralized decision-making gives line staff real authority in the program. Giving staff money to be responsible for and decide how to spend is a concrete, powerful step.
    2) The program should include a substantive consumer voice at every level of the program's decision-making process.
    3) "Consumer driven" needs to be an overt, highly discussed part of the culture to ensure that decisions flow, as much as possible, up from the needs of the people we're helping rather than down from administrative authorities.
    4) Planned risk-taking, not care-taking or abandonment, needs to be actively encouraged for both consumers and staff if growth is going to occur.
    5) Boundaries between staff and consumers need to be as low as possible to decrease the "us vs. them" stigma.
    6) Staff and consumers need to have multiple roles and multiple kinds of relationships with each other for consumers to move beyond illness roles in their recovery. Staff and consumers should help each other without "that's not my job" defensiveness or "that's your job" accusations.
    7) Staff and consumers should feel important, valued, and even treasured by those who have "positional authority" over them. Everyone is an expert in some way, a "chief" of something, with "personal authority."

3) **Healing:** In a recovery program the focus is on healing and growth for the person rather than symptom relief for the illness.
   1) The first priorities are engagement, welcoming, and relationship building because the foundation of a good recovery process is a good relationship, not a good diagnosis.
   2) A "counter culture of acceptance" needs to be established within the program to create an emotionally safe place for these "unacceptable," rejected people to recover.
   3) The usage of respectful language rather than prejudicial, clinical language needs to be so widespread that people can read their own charts or overhear staff discussing them and feel accepted and understood.
   4) A healing environment is an emotionally rich environment filled with open displays of caring and connection.
   5) To be effective, staff need to be in touch with why their hearts brought them into this work and be energized by practicing their gifts.

4) **Community Integration**: To achieve meaningful roles in life we cannot stay isolated away from the world.
   1) Both staff and consumers must be mobile and actually work together out in the community on "real life" issues.
   2) The program must demonstrate accountability to the community by collecting "socially responsible," quality of life outcomes including housing, jailing, employment, and finances.
   3) The program needs to focus on community coalition building and "giving back" to the community if the program and the people it works with are to be accepted.
   4) Staff and consumers need to be actively involved in the difficult work of fighting stigma if our world is going to become a better place for people with mental illnesses to live in.

It has become increasingly clear that leaders need to treat staff the way they want staff to treat consumers. Only staff who have hope, personal power, responsibility, and meaningful roles can help consumers have hope, personal power, responsibility and meaningful roles.

Defining a Recovery Culture

Recovery is gaining serious momentum and is being pushed on ambivalent and reluctant systems, programs and people by outside forces like legislative committees, presidential commissions and Proposition 63. Up to now, the first step has been to promote a belief in recovery by sharing first person accounts of recovery, producing research data about its existence, and describing the paths to recovery (my "four stages" is one of a number of well regarded examples).

The next step, currently underway, is to define and train in the practices that promote recovery (illness management, consumer staffing, supportive employment, Wellness Recovery Action Plan, rehabilitative goal setting, self-help, psycho-education, community integration, Assertive Community Treatment, medication collaboration, supportive housing, etc.).

Unfortunately, these practices are increasingly being disseminated through the medical culture that recovery is seeking to change. It is unlikely that the results of putting a few recovery-based practices within a medical culture to satisfy outside pressures will create successful recovery-based programs. Increasingly, we see the need to promote recovery-oriented cultures and leadership in order to create a fertile soil in which the seeds of recovery can grow.

Defining a recovery culture at this point of our development depends a lot on who you're talking to. One reason for the present momentum for the recovery culture is that multiple forces are coming together under the same banner, but they have different perspectives. In brief, there are four major forces:

(1) Consumers – They value consumer participation personally, programmatically, and politically ("nothing about us without us"). They focus on empowerment, widespread consumer staff, a focus on people instead of illnesses, choice, consumer satisfaction, break down of barriers between staff and consumers, quality of life opportunities (housing, employment, education, etc.), and respect as an anti-stigma tool ("stigma can be more disabling than symptoms").

(2) Rehabilitation services – These value an increase in individuals' functioning and participation in meaningful roles in the community even if there are still symptoms. Training programs, rehabilitative goal setting, supported quality of life services, role creation, coaching, and consumer motivation are their focus.

(3) Psychiatrists and the professional community – They often are seen as obstacles to recovery implementation, but a subset has been energetic in promoting an illness management model. Understanding illnesses, triggers and medications; stress management; coping skills; protective social networks; family and consumer psycho-education; intensive staff supervision and support (ACT); crisis alternatives to hospitalizations; implementing "best practices;" reimbursement parity; and reducing symptoms and their impact are their focus.

(4) Social and political systems – These want to impact the social and political costs associated with people with mental illnesses. Their values include reducing dangerousness,

homelessness, incarceration, hospitalizations and other social costs; integrating consumers with substance abuse problems; reaching out to unserved people; and collecting quality of life data to assess accountability and efficiency.

While these perspectives are clearly not contradictory to each other – in fact they are highly synergistic – it is rare for them to be integrated. Generally, people are only seeing their own priorities. A common result is less effective, fragments of recovery (such as a supportive employment program using an outside, unsupportive psychiatrist; a consumer program that excludes crisis or hospital interventions and loses credibility when it sends away people in crisis; a coping skills class without consumer staff as models; or a homeless outreach program without medications, substance abuse treatment, or trauma therapy).

As a field we are only beginning to integrate these values into a full recovery culture. Here is an attempt to describe elements of an integrated recovery culture for a recovery-based program inventory:

(1) High inclusion of consumers: Hire many consumer staff, not just in special consumer jobs. Reduce "us-them" distinctions (have shared bathrooms, work areas and meetings, and make it hard to tell who staff and consumers are). Promote safety based on "community watch" rather than separating and forcibly guarding consumers. Value consumer choices and input into goals, treatment plans and services. Give opportunities for consumers to have multiple roles besides treatment recipient. Reduce boundaries and use respectful, nonstigmatizing clinical language.

(2) Leadership and administration that treats staff the way we want staff to treat consumers: Emphasize staff hope, empowerment, responsibility (give them control over some funds and choices and promote "high risk-high support"), and meaningful roles. Encourage staff to take on multiple roles besides professional, so consumers can take on multiple roles besides patient. Allow lots of individual expressiveness. Value every staff as an expert in something. Encourage staff to be emotionally expressive and open about themselves with consumers and each other.

(3) Counter-culture of acceptance: Foster an ability to welcome and include difficult, socially undesirable, noncompliant people. Adhere to "no fail" rules and reach out to dropouts to minimize "lost to follow-up." Include charity as well as treatment. Have minimal coercion, rules to follow, exclusions, and "hoops to jump through." Make staff accessible both inside and outside the building and after hours. Make individualized, collaborative plans. Encourage staff willingness to engage in emotional, "real" relationships with consumers instead of keeping them at a "professional distance." Help staff develop a subjective awareness of what the consumer is going through and what that feels like.

(4) Holistic, integrated care focused on people not just their illnesses: Ensure that treatment plans, services and outcome measurement focus on quality of life. Organize generalist staff into teams with overlapping parts, not separate specializations. Limit "it's not part of my job." Collaborate with other social agencies (Social Security, Section 8, vocational rehabilitation, children's services, probation and parole) instead of just making referrals to other programs.

Integrate substance abuse treatment into every program and make it part of every staff's job. Help staff develop knowledge of life situations, not just diagnoses. Do "whatever it takes."

(5) High utilization of rehabilitative, recovery, and illness management techniques within a conscious framework of recovery promotion: Prioritize, regardless of funding availability, these services that promote recovery: supportive housing, employment, education, training, coaching, illness self-management, psycho-education and ACT. Help staff gain knowledge of recovery stages, goals, and individual progress ("what is the rehabilitation value of this activity?").

These elements can be further delineated and some even measured to create a recovery-based program inventory tool.

A RECOVERY-BASED PROGRAM INVENTORY

Throughout the country, there have been calls to transform the mental health system radically by making it recovery-based. However, it has often been difficult to describe in concrete terms and quantify the lofty ideals of the recovery movement. Even still, we must do so if we are going to catalyze the concrete and philosophical changes needed to truly transform most traditional programs. This inventory is an effort to translate the recovery vision into a practical program evaluation tool. I would appreciate feedback at mragins@village-isa.org.

1) Recovery Beliefs and Implementation

A) Do staff and consumers believe recovery from severe mental illnesses is possible?

- What do they base that belief on?
- What are their expectations for outcomes and prognoses?
- What institutional "outcome stories" do they share?
- Do treatment plans and goals reflect expectations of growth and development or of protection, care taking and stability?
- Does staff carry hope for consumers until they are able to hope themselves and does staff have specific techniques for building hope within consumers?
- Does staff have a positive possible future image of the consumers they're working with and do they help consumers build their own positive images?
- Is there an expectation, mechanism for, and/or regular process of "positive graduation"?
- Is there a positive exit from mental health services entirely?

B) Do staff and consumers believe in empowerment and self-determination?

- How much credibility is given to consumers' decision-making abilities?
- Do treatment plans and goals reflect consumer decisions or staff decisions?
- How frequently are services not "freely chosen:"
    - Program requirements?
    - Involuntary hospitalizations?
    - Conservatorships?
    - Court ordered treatment?
    - Payeeships?
- Is there an expectation, mechanism for, and/or regular process of restoring free choice in these services?
- Do consumer decisions substantially affect their individual treatment and services:
    - Goal setting?
    - Services they use?
    - Medications?
    - Frequency of treatment?
    - Staff they use?
- Do consumer decisions substantially affect the overall program design and operation?
- Are program information and developments openly shared with consumers?
- Are consumers included on advisory boards, planning and quality management committees, research planning groups?
- Are there concrete program choices that reflect consumer input?

C) Do staff and consumers believe in self-responsibility?
- Are there "natural consequences" for behavior or are there "therapeutic consequences"?
- Is there an effort to shield people from legal consequences because they have mental illness and therefore are not responsible?
- Are consumers "permitted to fail" or are they protected/rescued from failure?
- Are consumers expected to behave responsibly without supervision?
- How much freedom are they given from supervision within the agency (to use phones, supplies, mail, be around staff possessions, etc.)?
- Is program safety based on separating staff from consumers and forcibly guarding consumers or based on an inclusive "community watch" approach?

D) Do staff and consumers believe people with severe mental illnesses can contribute meaningfully to our world?
- Are people with mental illnesses hired at all, in restricted consumer positions, and/or as fully equal staff:
  - Do they volunteer, receive reduced wages, and/or full pay?
- Does the program support community employment:
  - Fully paid, sheltered, and/or subsidized?
  - Enclave, protected, and/or "nondisclosure"?
- Are there roles in the program besides treatment recipient roles:
  - Are consumers actively engaged to help each other?
  - Do consumers co-lead and/or lead program activities?
- Are consumers kept within the program walls or supported within the community?
- Are community activities basically interacting with other consumers or with "normal" community members?
- Are there integrated, "nondisclosure" community activities?
- Do treatment plans and goals reflect meaningful community roles:
  - Employment?
  - Reconnecting with family?
  - Raising children?
  - Intimate relationships and marriage?
  - Spiritual involvement?
  - "Giving back" to others?

2) Recovery Relationships and Leadership
A) Are relationships between staff and consumers highly valued?
- Does the intake procedure emphasize relationship building or diagnostic assessments and paperwork?
- Is continuity of relationship maintained in the intake process?
- Are treatment assignments based on relationship fits?
- How are relationships built during treatment transitions:
  - In crisis?
  - In hospitalizations?
  - In staff vacations?
  - In staff departures?
  - In discharges?

A) Are relationships between staff and consumers highly valued? (cont'd)
- How many staff do consumers generally have relationships with?
- How much of the treatment activity is overtly relationship building in intent?
- Do administrators have relationships with consumers?

B) Does staff relate to consumers as people or relate to their illnesses?
- Do their interactions and notes reflect only illness concerns or include personal concerns?
- Are subjective experiences explored or is only an objective symptom checklist used?
- Do goals reflect consumers' personal individuality or illness status?
- Are consumers assigned to and grouped into services based upon illness or personal factors?
- Does staff have other roles in the program besides their illness-related roles when they interact with consumers?
- Are there program activities designed to encourage staff and consumers to interact away from their illness roles:
    - Are they outside the program grounds?
    - Are they outside normal working hours?
    - Are there different authority relationships?
- Is the language used by staff, with each other and with consumers, respectful and nonstigmatizing?

C) Are the barriers between staff and consumers minimized?
- Is there an atmosphere of staff and consumers sharing ownership of the program and living/working together or are staff running the program for the consumers?
- Are there physical barriers between staff and consumers?
- Are there segregated bathrooms, lounges, telephones, work areas, eating areas, etc.?
- Is it hard to tell who is a consumer and who is a staff?
- Do interactions appear artificial and professional or real and personal?
- Is staff encouraged to share their personal experiences with consumers?
- Is staff encouraged to be emotionally expressive with consumers?
- Is there positive physical contact (e.g. hugs, pat on the backs, high fives) between staff and consumers?
- Does staff tend to treat consumers patronizingly?
- Is staff fearful and mistrustful of consumers?
    - Has there been significant harm done?
- Are consumers fearful and mistrustful of staff?
    - Has there been significant harm done?

D) Is staff treated the way we'd like consumers to be treated?
- Is administration hopeful about its staff?
- Does administration expect its staff to help consumers improve their lives?
- What outcomes do they hold staff accountable for?
- Is staff encouraged to make their own treatment decisions?
- Is staff given funds to spend directly on their consumers?

D) Is staff treated the way we'd like consumers to be treated? (cont'd)
- Is staff encouraged to try new things?
- Is staff encouraged to take risks or is there a "culture of blame"?
- Is staff encouraged to be emotionally expressive with each other?
- Is staff encouraged and funded to build their own expertise?
- Is staff consulted as "experts" by their own administration?
- Are program information and developments openly shared with staff?
- Is staff included on advisory boards, planning and quality management committees, research planning groups?
- Are there concrete program choices that reflect staff input?
- Is staff expected to behave responsibly without supervision?
- Is staff encouraged to find meaningful roles in the program?
- Is staff encouraged to develop "complementary interests" in the community and share them with consumers?
- Is staff expected to grow both within the program and to move on to other opportunities?

E) Does the program's administration reflect recovery values?
- What is the mission statement of the program and how is it implemented?
- What issues does administration spend its time and leadership on?
- What issues does administration advocate for outside the program?
- How are competing pressures and auditors handled?
- How is risk management handled?
- Are administration desires forwarded through rules or values?
- Do internal funding choices reflect person-centered recovery planning?
- Does programming and funding follow consumers as they grow?

3) Recovery Culture
A) Is welcoming widespread?
- How are inquiries about the program handled?
- Is there a "no wrong door" policy, finding help for everyone somewhere?
- Are there physical barriers to welcoming?
- Is there widespread staff accessibility:
  - Walk-ins?
  - Telephone calls?
  - Cross coverage?
  - After hours?
  - Comfort and crisis?
  - Family and others?
- Is there serious pressure to get rid of consumers and potential consumers?
- How are services rationed and how does that affect the culture?
- Are there substantial waiting lists?
- Are there program restrictions, exclusions, or requirements, "hoops to jump through," which restrict access?
- Does staff initiate extra contact with consumers?
- Does staff seem genuinely happy to see consumers?
- Does staff reach out to dropouts and minimize "lost to follow-up"?

B) Is the program charitable?

- Does the program directly give people practical assistance:
    - Food?
    - Housing?
    - Transportation?
    - Clothing?
    - Mail?
    - Phone?
    - Storage?
    - Hygiene? (showers, shave, laundry, hair cuts, etc.)
- Does the program indirectly give people practical assistance:
    - Referrals to local resources?
    - Assistance with applying for outside benefits (e.g. SSI applications, bus handicapped identification, disabled students' offices, Section 8 forms, medical and dental care, etc.)?
    - Accompany consumers to outside practical resources?
- Does the program develop outside practical resources?
- Is practical assistance always linked to treatment goals and requirements or can it be charity or engagement?

C) Does the program create a counter-culture of acceptance?

- How restrictive are the standards for "appropriate behavior" for consumers?
- How accepting is the program of "non-compliant" consumers:
    - Medication refusals?
    - Ongoing substance abuse?
    - Refusal to live in treatment settings?
    - Refusal to attend recommended groups?
- Are there punitive or exclusionary rules for inappropriate behavior or noncompliance?
- How are "bannings" handled?
- Is there a widespread effort to understand consumers' subjective experiences and the reasons for their behaviors?
- Is there widespread staff with personal experience with mental illnesses, substance abuse, homelessness, jailing, or other personal tragedies?
- Is there an inclusion in the program of socially undesirable consumers?

D) Is the program a safe sanctuary?

- Do consumers feel safe from the outside world within the program?
- Are consumers helped with criminal issues or just turned over to the police?
- How often are consumers involuntarily hospitalized for their behaviors?
- Is there physical violence within the program?
- Are the consumers protected from social stigma within the program or are they discriminated against, disrespected, and stigmatized within the program too?
- Do consumers feel safe enough to expose themselves emotionally to staff and to each other?
- Do consumers feel safe enough to reveal shameful issues (e.g. childhood trauma, illiteracy, substance abuse, prostitution)?

D) Is the program a safe sanctuary? (cont'd)
- Are consumers able to learn from their mistakes?
- Is there a "no fail" policy?
- Why are consumers "86'd" from the program?
- Is there a sense of "spiritual acceptance" in the program?

E) Does the program embrace consumers' lives within it?
- Do consumers behave in the program like they do outside or act like patients within the program?
- Do consumers bring in their families, friends, lovers, and children to share with the program?
- Are consumer belongings, creations, and gifts widespread in the program?
- Do consumers share non-patient activities with the program?
- Is staff knowledgeable about consumers' lives?
- Does staff share ideas and resources relevant to consumers' outside lives with consumers within the program?
- Are "sensitive" parts of life openly included in the program:
    - Physical appearance?
    - Sexual feelings and behaviors?
    - Spirituality?
    - Child rearing?
    - Substance abuse?
    - Criminal behaviors?
- Does the program feel "full of life"?

4) Recovery Treatment
A) Is treatment focused on improving lives or treating illnesses?
- Are quality of life outcome data collected?
- Does goal setting reflect quality of life or clinical goals?
- Are there substantial services in the quality of life areas:
    - Housing?
    - Finances?
    - Employment?
    - Education?
    - Legal?
    - Physical health?
    - Substance abuse?
    - Social?
- Are services selected based on quality of life needs or clinical needs?
- Is there widespread staff with expertise in various life skills rather than mental health skills?
- Does staff "life coach" around practical skills and goals?

B) Is treatment integrated?
- Are services organized in teams working together or do staff pursue their own specialized goals and services?
- Is supervision organized around each consumer or by specialty service?
- Does all staff have an overall knowledge of the consumers they work with?

B) Is treatment integrated? (cont'd)
- Is there ongoing substantial communication between staff, including the psychiatrist, to coordinate services?
- Does staff act as overlapping "generalists" and do "whatever it takes"?
- Are there substantial internal referrals because "that's not my job"?
- Are there substantial external referrals because "that's not our job"?
- Is substance abuse treatment integrated into all staff services and relationships?

C) Does treatment utilize rehabilitation and recovery techniques and practices?
- Are services overall provided with a care taking or training emphasis?
- Are effective rehabilitation services provided:
  - Illness education and self-management?
  - Supportive housing?
  - Supportive employment?
  - Family psycho-education?
  - Supportive education?
  - Harm reduction and motivational interviewing?
  - Financial planning?
  - Supportive socialization?
- Is staff actively aware of the recovery stage, goals, and individual progress of the consumers they work with?
- Is staff actively aware of the "rehabilitation value" of their activities?
- Are consumers learning to manage their own lives through gaining recovery and life skills within a conscious framework of recovery promotion?
- Are consumers learning ways to manage symptoms?
- Are consumers learning ways to manage feelings?
- Are consumers learning ways to calm and center themselves (e.g. meditation, yoga, exercise)?
- Are consumers learning proactive ways to deal with crisis (e.g. WRAP plans, advanced directives)?
- Are consumers building trust in their own decision-making and skills?
- Are consumers learning to find meaning in their suffering, to create wisdom from their pain?
- Are consumers preparing themselves to be independent of the program?

D) Does treatment build community supports and community integration?
- Does staff spend substantial time in the community, with and without consumers?
- Does staff actively collaborate and build relationships with other social service agencies:
  - Social Security?
  - HUD and Section 8?
  - Vocational Rehabilitation?
  - Children's Services?
  - Police, courts, jails, probation, and parole?
  - Disabled students services?
  - Welfare programs?
  - MediCaid/MediCal and MediCare?

D) Does treatment build community supports and community integration? (cont'd)

- Does staff actively collaborate and build relationships with "community providers:"
    - Medical, dental, and eye services?
    - Schools and vocational training programs?
    - Employers?
    - Landlords and apartment management companies?
    - Board and care operators?
    - Recreational programs and adult education?
    - Food providers?
    - Religious organizations?
    - Substance abuse treatment and sober living?
- Does staff actively collaborate and build relationships with self-help and consumer-run services of various kinds?
- Does staff actively collaborate and build relationships in the community for consumers to have non-consumer roles?
- Does staff focus on replacing themselves with "natural supports" in the community?
- Does staff actively engage in mental health advocacy and stigma reduction activities?
- Does staff get involved in making the community a better place for everyone?
- Is the program a good neighbor?

A Wish List of Broken "Rules"

In 2003, the President's Commission on Mental Health boldly called for transformation of the entire mental health system, declaring that we were beyond repair. I have participated in efforts, on many levels, to begin this transformation. In general, people are highly responsive to adding resources and programs to what they presently do. In general, people are highly resistant to destroying, or even substantially changing, what they presently do. The old saying, "I'm in favor of progress; it's change I'm uncomfortable with" has popped up several times.

Yet transformation does require substantial destruction. On a systems level, resources for creating the new have to come from the old (although California is making a strong effort with Proposition 63 to create substantial new resources to promote this effort). On a personal level, every one of us has to stop doing something familiar to start doing something new.

The MHA Village began as a model for a transformed mental health system. We put together a video clip to help champion this process of change. In the clip, Ernie from "Sesame Street" has to put down his rubber ducky to be able to play the saxophone. He needs a lot of persuasion and has a hard time letting go, but eventually he makes it.

In 2004, a pair of UCLA anthropologists studied the MHA Village to try to figure out why we're so consistently successful and why we're so difficult to replicate. Their conclusion was both startling and somewhat disturbing. They concluded that the Village worked because we "treated people like people." They described how, far from a normal process, it required enormous will to fight the powerful forces that work against "treating people like people." Many of these forces, they felt, are imbedded in our professions and our treatment culture in the hegemony of mental health.

They detailed many of the Village's strengths. We have a powerful rehabilitation/recovery vision and practice; a protective lead organization, the National Mental Health Association of Greater Los Angeles; good internal communications; a flat organizational structure; and a high ability to adapt and change while preserving our values. These traits have given us strength to maintain "treating people like people," in spite of constant regressive pressure from the system.

We can't expect every program to have the Village's resources and strengths, which are needed to fight the system. If we are to spread recovery, the President's Commission is correct. The system itself must be transformed.

The system is maintained through a network of "rules." Some of these are actually legal or professional rules, but most are just "the way things have always been done." We must re-examine these rules and willfully destroy those that prevent recovery programs from developing. Unfortunately, they exist on a number of levels and come from several sources, which makes our efforts to break them more difficult.

Here's my Wish List of Broken "Rules:"

1) **Funding must not support only clinical services**. Clinical services in isolation do not work very often. Most supports (housing, employment, financial, education, etc.) can only be used effectively by people with severe mental illnesses when they have lots of help. This help needs to be integrated into clinical services. The dominant funding source for public mental health services is Medicaid (MediCal in California). This is a medical insurance plan that pays only for "medically necessary" services. It is also a diagnosis-based plan. Medicaid often says that it is not forbidding us from providing support services; it just doesn't think its medical insurance plan should pay for them. Breaking the rule that Medicaid is just a medical insurance plan would address this problem. The rehabilitation option and some waivers have begun to move us in this direction.

The problem is compounded, however, because when other funds are available (e.g. county or state general funds, housing support funds) the usual rule is that these funds must be used to leverage additional Medicaid funds to the maximum degree possible. This rule forces us to use less-restricted funds in accordance with Medicaid rules. Even though the total dollar available may be less, we need to use other funds to supplement Medicaid, not just to leverage it.

2) **Programming must not be limited to clinical services**. Obviously this would be easier if funding rules were changed, but there are more rules that need to change. Goals should reflect quality of life outcomes, not diagnosis-based symptom reduction. Outcomes that reflect quality of life (housing, employment, education, income, etc.) need to be collected, instead of symptom level outcomes (or no outcomes at all).

The "it's not my job" rule needs to be broken. Money management/payee, supportive housing, jail diversion, employment, community integration, etc. are our job. We also should break the rule that clinical services, especially emergency and hospital services, need to be provided first with support services provided as a lower priority. (This rule is fortified by medical liability rules whereby people are sued for not providing "appropriate" emergency care, but are not sued for not providing "appropriate" support.)

3) **Staffing must not be limited to clinical professional staff**. Assigning clinical staff to do needed quality-of-life, support services creates resistance and resentment. Social workers aren't payees, psychiatrists aren't job developers, and psychologists aren't self-help leaders. Only a portion of an integrated service program's staff should be clinical professionals. Staff should include non-professional case managers, consumers, family members, employment staff, community integration staff, substance abuse specialists and health care nurses. Beyond that, creating collaborative relationships with lots of different people with mental illnesses requires teams to be multiexperiential, not just multidisciplinary.

4) **Program accountability based on counting units of service documented in patient's charts must be replaced by outcomes accountability**. Programs spend enormous amounts of resources (estimated about 30 percent of total funds) to be accountable and auditable in the present systems, virtually none of which are either useful clinically or reflect patient outcomes. This rule is too costly not to be destroyed and replaced with outcomes accountability.

5) **Risk management and liability avoidance must not rely on risk avoidance**. While it is true that it is hard to be sued for not giving someone an opportunity to grow and recover, it's not the only way to avoid lawsuits, and it is the way most destructive to recovery programs. Risks are to be prepared for, supported, and learned from, not just avoided. Conscientious preparation and ongoing supportive relationships can be a protection from tragedies and lawsuits.

6) **Multiple roles for service providers must not be forbidden**. A holistic model like recovery requires that staff be holistic. For a person to embrace other roles besides helpless, cared for, chronic mental patient, staff need to embrace other roles besides helping, caretaking, mental health professional. We can best be effective promoters of recovery by not restricting ourselves. A psychiatrist can help by being a customer at a clubhouse restaurant, a fellow sports fan, a neighborhood clean up volunteer or a wedding guest. Self-disclosure, as long as staff doesn't use it to unburden themselves, usually builds relationships and promotes recovery.

7) **Staff - client boundaries must not be strictly maintained**. Breaking down the "us vs. them" distinction is essential to promoting recovery and fighting stigma, but strict boundaries reinforce that distinction. With lower boundaries, ethics become more important and the responsibility of the entire team. The rules against exploiting patients, having sex with clients, assaulting and abusing clients should *never* be broken.

But, we can't promote recovery while preserving the enormous thicket of rules that have proliferated from these few essentials. Hugging, sharing feelings, accepting gifts, making home visits, giving people rides in our cars, eating together, sharing bathrooms, attending social events together and talking outside of "therapy hours" may be problematic in specific situations, but shouldn't be globally forbidden. Those are often the very actions that people find the most caring and helpful. The most productive way to break both the role rules and the boundary rules is to hire numerous people with severe mental illnesses as program staff.

8) **Protecting blanket confidentiality must be replaced with protecting patient choice**. The underlying purpose of confidentiality was not to promote secrecy and isolation. The purpose of confidentiality was to protect against unconsented and unchosen sharing. Often, sharing with other people can be very healing; generate emotional and practical support; decrease stigma and increase community integration; and reduce isolation, hopelessness and suicidality. Staff who make automatically make decisions to keep all information private aren't really respecting the person's right to choose.

9) **Protecting staff by restricting patients to small guarded areas must be replaced by protecting everyone together**. Isolating, coercing, and disempowering people leads them to become more frustrated and dangerous, both to staff and to each other. Including, collaborating with, and empowering people leads to shared responsibility for protecting each other, "a community watch." We can't urge our communities to accept people with mental illnesses while we quarantine them in our own programs.

10) **Separation of mental health and substance abuse services must be replaced with integration**. The overlap is so enormous that there is barely any rationale for specialized services that exclude one or the other. Even collaboration between specialty services is unlikely to produce good treatment. Full integration of patients, staff, and programs is the most effective approach. Unfortunately, the rules against this integration exist on numerous levels: funding, staff comfort and expertise, social stigma, political leverage, and moral and emotional reactions.

11) **Rationing services by diagnosis must be replaced with rationing by disability and life impact**. The present system has acceptable "severe mental illnesses" and unacceptable, presumed less severe illnesses. In practice, however, people may become severely disabled and their lives may be destroyed by a wide variety of conditions. Both social responsibility and individual humanity dictate that we don't turn away disabled, destroyed people just because they have the wrong diagnosis. This diagnostic rationing rule leads to patient lying, incorrect diagnosis and treatments, and widespread hypocrisy, all unnecessarily. Rationing care is an unfortunate reality, but rationing by diagnosis isn't the right rule to use.

I believe a transformed, effective, recovery-based mental health system will have to destroy all these rules before these rules destroy the programs and the people trying to change.

Biography

Mark Ragins, M.D., is the medical director of the MHA Village, an integrated service program of the National Mental Health Association of Greater Los Angeles. Located in Long Beach, California, the Village is an award-winning model of mental health care that is being replicated nationwide.

Dr. Mark has been with the Village since it opened in 1990, working as a team psychiatrist and as part of its Homeless Assistance Program. Over the years, he has been active in promoting system change, focusing on integrated services, rehabilitation, and recovery for people with serious mental illnesses. He has given more than a 100 presentations and lectures to wide ranging audiences nationally and internationally. He most recent booklet, "A Road to Recovery," is available at www.village-isa.org.

He was the co-winner of the American Psychiatric Association's Arnold van Ameringen Award for Psychiatric Rehabilitation in 1995. The MHA Village received the Gold Medal Award, the APA's highest honor for community programs, in 2000.

Dr. Mark says: You may also be interested to know that I'm a Los Angeles native, married with two teenage sons. I was well educated at Caltech, attended medical school at Washington University in St. Louis, and did my residency at the Los Angeles County-USC Medical Center. I have traveled widely, including taking a four-month trip with the kids to 23 countries, during which I made lots of visits to psychiatric programs. I have also been trained as a Reiki Master. When my kids were little, I coached them to the world finals in "Odyssey of the Mind." I'm trying to co-write a "real book" about the MHA Village, but we can't find a publisher. Underneath it all, I'm still the little kid who drove my teachers crazy by asking "Why?".